General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Boots, 164 High Street, Musselburgh, MUSSELBURGH, Midlothian, EH21 7DZ

Pharmacy reference: 1042766

Type of pharmacy: Community

Date of inspection: 01/12/2021

Pharmacy context

This is a community pharmacy on the main road of Musselburgh, a small town close to Edinburgh. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to people living in care homes. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.1	Good practice	The pharmacy identifies and manages risks to its services well. And team members actively learn when things go wrong. They use feedback from external stakeholders and previous inspections to make improvements. And they share this learning with the whole team.
		1.2	Good practice	The pharmacy regularly records and reviews mistakes that the team members make. And it uses this information well to identify areas for improvement. It reviews its processes and services and takes action to improve them. And it monitors and reviews these actions to make sure they are appropriate.
		1.4	Good practice	The pharmacy proactively encourages feedback from people using the pharmacy, including from care home teams. It actively uses questionnaires to find out what people think about its services. And it uses this feedback to improve services.
2. Staff	Standards met	2.1	Good practice	The pharmacy continually monitors its staffing levels and skill mix, making appropriate changes as required. Senior team members review workload throughout the day, making temporary changes to ensure there are always sufficient team members to safely provide the pharmacy's services.
		2.2	Good practice	The pharmacy has a culture of training and development. And it makes sure team members have regular protected time for training. New team members follow a suitable induction programme and have regular discussions with their line manager to ensure they are competent for the tasks they carry out. The pharmacy assesses its team members' competence before they complete new tasks.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including	Standards met	N/A	N/A	N/A

Principle	Principle finding	Exception standard reference	Notable practice	Why
medicines management				
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages risks associated with its services well. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make effective changes to avoid the same mistakes happening again. The pharmacy encourages and uses people's feedback well to improve its services. It keeps all the records it needs to by law, and it keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and between workstations in the dispensaries. And it had hand sanitiser available. Earlier in the pandemic the pharmacy had marked the floor to encourage social distancing and limited the number of people on the premises. But this was no longer in place as team members managed queues better than they had previously. And the premises were large enough for people to socially distance. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day.

The pharmacy had standard operating procedures (SOPs) that team members followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years, or more frequently, and signed them off. Staff roles and responsibilities were recorded on individual SOPs, and the sign-off sheet clarified which team members were deemed competent in each procedure. Recently new controlled drugs' SOPs had been issued and relevant team members were working through these. New team members read SOPs that were relevant to their roles, gradually reading more as their roles developed. A pharmacist assessed them and signed them off when they were competent. This ensured that processes were embedded, and they were not overwhelmed with unnecessary information. They only undertook tasks that they were competent in and worked under close supervision as they learnt additional processes. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. When the responsible pharmacist was on a break, they recorded absence, but another pharmacist was present to enable all pharmacy services and processes to continue. The pharmacy managed dispensing, a high-risk activity, well, with baskets used to differentiate between different prescription types and separate people's medication. It had a well-defined and effective process in place to enable accuracy checking pharmacy technicians to carry out final accuracy checks on dispensed medicines. A list of similar sounding or looking medicines was displayed in checking and dispensing areas to remind team members to be especially vigilant when dispensing these items. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. The pharmacy displayed the monthly patient safety review in the dispensary for team members to refer to. There were measurable actions that were monitored to ensure improvements were embedded. The

electronic dispensing system provided analysis, showing trends which helped with the learning. An increase in incidents was identified a few months previously when there were a lot of changes within the team, and changes were implemented to improve processes. At that time the team had also improved its reporting culture, so some of the increase was down to better recording. There had been no poor outcomes. One common error was supplying the incorrect quantity of tablets. This was reported as due to there sometimes being several packs of the same medication open, and not marked as such. This occurred because there were two dispensaries. So, all team members were reminded to mark split packs. Following any handing-out errors, team members followed a checklist and they were observed. One contributing factor identified was related to chatting to the person while handing out medicines. Team members were reminded that it was appropriate to say to people that they needed to concentrate and pause conversations.

The pharmacy had a complaints procedure and welcomed feedback. A dispenser in the care home dispensary had a role liaising with care homes as, 'Care Service Customer Partner'. One of her first tasks had been to develop a questionnaire about the pharmacy's service, for each home to complete. There had been a lot of good feedback about the pharmacy on the questionnaires, and also to the pharmacist working with care homes locally at a higher level. Some feedback was on a 'celebration board' on the staff notice-board for all team members to see. This included positive comments about individual team members. Following some feedback the dispenser had developed a medicines' re-ordering template which was laminated and provided to all homes. The homes had welcomed this and were using it effectively. The pharmacy encouraged people to feedback to head office with any comments or concerns about the pharmacy. The pharmacy had used feedback from the previous inspection, and the resulting action plan, to engage with all team members, review knowledge and processes and share details of work being undertaken to raise standards.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and kept an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertook annual training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacists were registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme. Team members were aware of the 'Ask for ANI' (action needed immediately) and safe space initiatives for victims of domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its service. They are trained and competent for their roles and the services they provide. The pharmacy has a strong culture of effective training and development. And it supports team members with protected time for training during the working day. Team members make decisions within their competence. And they use their professional judgement to ensure the pharmacy delivers its services safely and put people's health and wellbeing first. Team members make suggestions and raise concerns to help provide the best service possible.

Inspector's evidence

The pharmacy had one full-time pharmacist manager, two full-time pharmacists and a part-time assistant manager who was a trainee healthcare assistant. The pharmacists had been in this pharmacy for several months and worked well together. When both pharmacists were working the pharmacist manager completed managerial and other tasks. There were three part-time customer advisors who had not completed pharmacy training and looked after the retail area. During the height of the pandemic, they had undertaken some pharmacy training including being assessed and competent on the tasks within some core SOPs, to enable them to support the pharmacy team. A full-time dispenser from the care home dispensary had recently moved to work at the medicines counter to ensure there was a team member available for people most of the time. This minimised interruptions in the dispensary. Some team members worked in both dispensaries, but mostly they worked as two teams. The main dispensary had a full-time pharmacy technician, and two full-time dispensers, one qualified and one undertaking training. Two team members had started the previous week to cover long-term absence. Neither had worked in pharmacy before, so they had spent time with colleagues being shown how to complete tasks such as putting medicines away and handing out dispensed medicines. They had read SOPs relevant to what they were doing so far. And they had been registered on accredited courses. They knew that they must complete training and the pharmacy would provide protected time for this. And they described how team members answered their questions and helped them. The pharmacist manager was observed to informally ask them how they were doing and check that they felt supported. There were two 'Saturday only' dispensers, one trained and one undertaking training. The care home dispensary had one full-time and one part-time accuracy checking pharmacy technician (ACPT), three full-time dispensers and four part-time dispensers. One was a care service customer partner who split her time between working in the dispensary and working with the care homes' team members to build relationships and improve ways of working together. The pharmacy had planned for the new trainees to spend time in both dispensaries and they had already had a day in the care home dispensary as part of their induction. The pharmacy shared delivery drivers with other branches in the area and they were managed from a central hub.

Team members were able to manage the workload. The pharmacy had experienced some challenges over the past year related to workload and staffing levels. When the pharmacist manager had started a few months previously she had worked with area and regional teams to improve standards and stabilise the team. During this time vacancies were backfilled with trained team members from other branches. The pharmacy did not recruit for new team members until it was stable, and processes were running well. The pharmacist manager had reviewed staffing levels considering long-term absences and some resignations and had recruited to fill these positions. Some part-time team members had some scope to

work flexibly providing contingency for absence.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development and it provided team members undertaking accredited courses with additional time to complete coursework. The pharmacy had a training timetable on a staff notice board with notes of what to focus on, for example, course work for trainees and other material such as the 'Professional Standard', patient safety and compliance training. Records of progress were recorded on a progress log and skills matrix. Pharmacists supervised trainees.

Team members had annual development meetings with their line manager. A pharmacist described topics discussed, with a focus on training and embedding new ways of working. Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. Several examples were described of team members providing positive and negative feedback to the pharmacist manager. And team members shared examples of action taken following such feedback. This included consolidating split packs of medication and tidying storage drawers which reduced the risk of selection errors. When posed with a scenario, a team member convincingly demonstrated how she would advise and encourage colleagues, including locum pharmacists, to make difficult decisions in people's best interest. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this document, the 'Professional Standard' and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The pharmacists, assistant manager and pharmacy technicians met each morning to discuss and plan the day ahead. They then cascaded plans for the day to other team members to ensure all tasks were undertaken efficiently and timely. Sometimes this involved team members being re-deployed to the other dispensary if there was a particularly heavy workload. And workload was reviewed throughout the day and team members moved as required. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members offered services according to the needs of people. And they were not incentivised. The pharmacist manager shared data such as how many Pharmacy First consultations the pharmacy had delivered. This was noted on the staff notice board, demonstrating to team members the benefit to people's health, and encouraging them to promote and provide the service to more people.

Principle 3 - Premises ✔ Standards met

Summary findings

The spacious pharmacy premises are safe and clean and suitable for the pharmacy's services. The pharmacy has suitable facilities for people to have conversations with team members in private. The pharmacy team members respect and manage people's confidentiality. The pharmacy is secure when closed.

Inspector's evidence

These were large premises incorporating a retail area, dispensary at the rear of the premises, and an upper floor with a care homes' dispensary, staff facilities, offices, and storage space. The premises were clean, hygienic, and well maintained. Team members cleaned surfaces and touch points more often than before the pandemic. There were sinks in the dispensary, staff room and toilet areas. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in several locations. The pharmacy had masks and lateral flow Covid tests in staff areas for team members to use. Temperature and lighting felt comfortable throughout the premises.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk and chairs, which was clean and tidy, and the door closed providing privacy. When using this room team members observed social distancing as much as possible and minimised time in the room. It had a hatch through to the dispensary, so people who consumed their medication in the pharmacy, did so in this room in private . Team members passed their medicine through the hatch.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely and effectively. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with information, and suitable advice to help them use their medicines. And they support care home teams by providing them with additional training and advice to help them administer medicines safely. The pharmacy obtains medicines from reliable sources and stores them properly. It manages stock levels carefully ensuring it has the appropriate amount of medicines in stock. Team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services in public areas and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as flu vaccination. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Workflow was observed to be smooth and efficient. A new computer system had been implemented a few months previously. All team members were fully trained and competent using it. It was contributing to better efficiency and accurate dispensing using bar code technology. Team members described some functions and explained that it had improved some processes such as accurate retrieval and supply of dispensed medicines. Dispensing team members shared clinical information and any changes to prescriptions with pharmacists and ACPTs using pharmacist information forms generated by this system. This ensured that appropriate advice was given to people about their medicines, or queries could be made to prescribers. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. They also initialled prescriptions to provide an audit trail of personnel involved at every stage of the dispensing process including labelling, clinically checking, accuracy checking and handing out. This identified prescriptions suitable for an ACPT to carry out the final accuracy check. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these prior to an agreed date, ensuring medicines were ready when people expected them. The pharmacy also sent text messages to people notifying them that their medicine was ready to collect. The pharmacy recorded the dates medicines were collected and when future supplies were due. There was no evidence of poor compliance.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They kept robust records and tracked the progress of these prescriptions. Team members included tablet descriptions on the packs and supplied patient information leaflets with the first pack of each prescription. They were currently assessing people's suitability for early supply over the Christmas and New Year holidays. The pharmacy

supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were mostly stored in the standard retrieval drawers and supplies were recorded electronically on the dispensing system. Some medicines were stored securely to comply with legislation. The pharmacy labelled instalment medicines with the dates of dispensing and supply.

The pharmacy also provided pharmaceutical services to care homes. This was a big part of the pharmacy's work and was managed in a separate dispensary, with a dedicated team of competent and well-trained team members. They rotated through all tasks to maintain their skills and competence. They generally worked no more than two days per week on interim prescription dispensing as this was high pressure work. The pharmacy had a range of SOPs related to this service that had been read and signed by relevant team members. This folder was kept in the care homes' dispensary and included copies of some core SOPs for reference. The dispensary was well laid out and organised. There were logical streamlined processes in place. This included dedicated workstations for priming (checking prescribing accuracy, generating labels and medicines administration (MAR) sheets), clinical checking, routine monthly dispensing, interim prescription dispensing and interim prescription accuracy checking. Team members were very clear about the processes and could describe them well. They described what they would do if an urgent prescription had been received past routine cut-off times for supply. The pharmacy delivered medicines to the care homes. And it worked to a schedule including dates/times that prescriptions must be received, and times that medicines must be ready for delivery drivers to collect the medicines. The whole process had been reviewed over the past few months. All team members had been involved, all making suggestions for improving efficiency and dispensing accuracy. Several changes had been implemented. These included storing stock medicines ordered or selected for the following day's dispensing out with the dispensary. This meant that shelf space had been released. And team members now gathered medicines to dispense in the other area where there was more space, and this reduced the number of people moving about in the dispensary. Team members now handed over medicines for supply to the delivery drivers in this external space, again reducing the number of people in the dispensary. This reduced noise and distraction which helped concentration. And excess medicines were now removed from this area and taken to the main dispensary at the end of each day. This helped ensure only medicines required were on the shelves, keeping them clearer and tidier which reduced the risk of selection errors. The pharmacy received a lot of obsolete medicines back from care homes. In the past this had not always been dealt with in a timely manner. But currently a team member dealt with it at least fortnightly which avoided large accumulations which could introduce risks and take up a lot of space. The obsolete medicines included controlled drugs, which were segregated immediately and stored securely. And these were destroyed at least fortnightly. The pharmacy was working with the health board to try and find acceptable ways of reducing the amount of waste medicines. The Care Service Customer Partner had a role providing training to care home teams. This was limited during the pandemic but there were plans to progress it over coming months. She was currently undertaking the Boots training course that care home staff completed, to help her build on their knowledge and support them with their training. She had previously completed courses on dementia and end of life care which helped when training and discussing issues with care home teams.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and

chlamydia treatment. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. The pharmacy was not currently providing additional services. The team had decided not to offer flu vaccination this year due to the changes in staffing and processes. A risk assessment had identified that this would put additional pressure on the team.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy stored items requiring cold storage in three fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. A lot of work had been undertaken by all team members over the past six months to improve how medicines were managed and stored. Initially a lot of excess medicines had been identified. Some functionalities of the computer system had been used to ensure the correct and appropriate quantities of medicines were kept. Some excess had been moved to other pharmacies, and some had been used in the pharmacy, adjusting electronic stock levels to allow the system to accurately manage the stock levels. Team members had been trained to use the system and key people undertook accurate stock counting. All medicines storage areas were observed to be very tidy and ordered. This was a great improvement from the last inspection. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services. And it looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. And they kept clean tablet and capsule counters in the dispensary and including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and care home dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.